

Solitary Solid Pulmonary Nodule

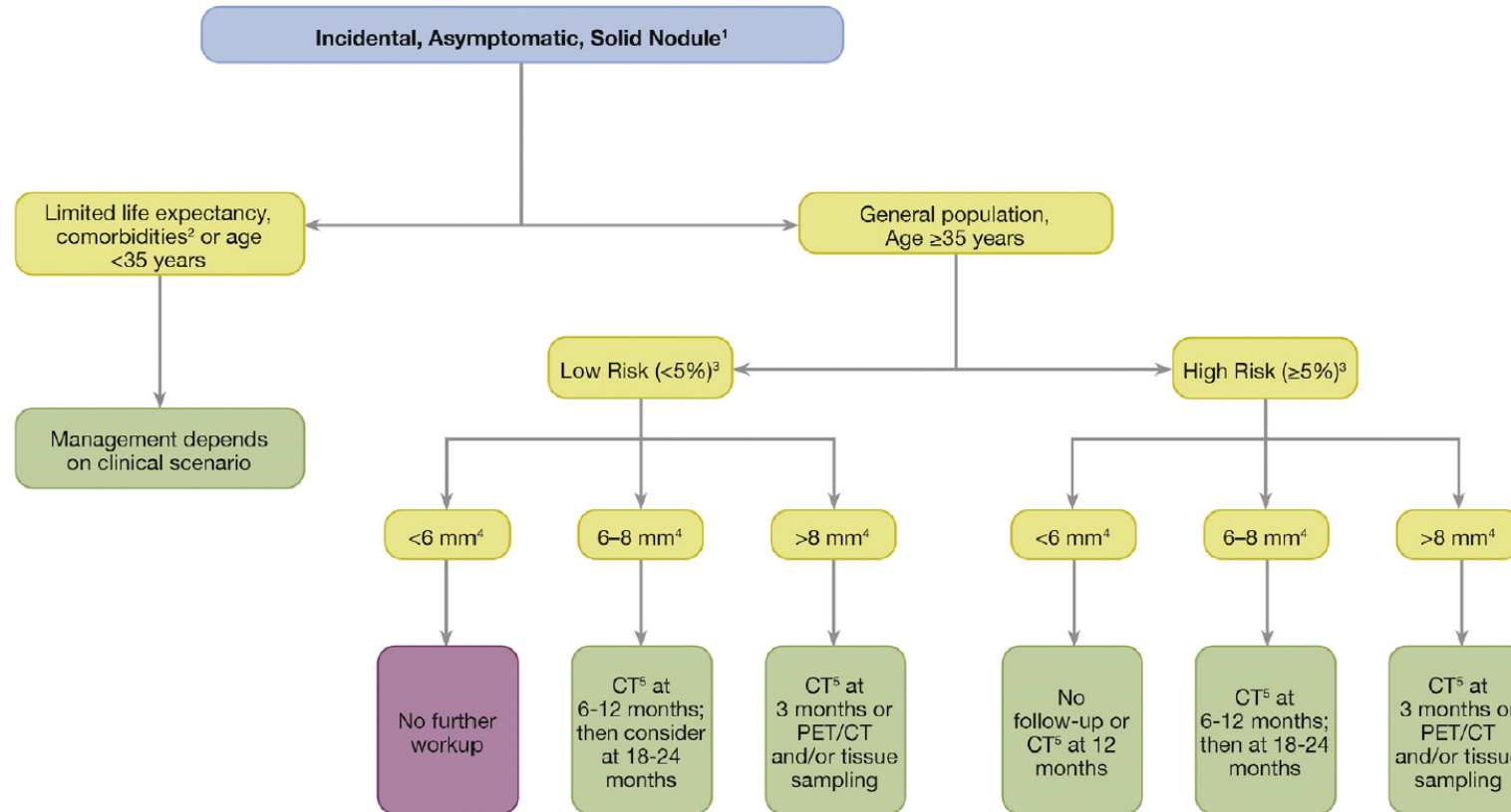


Fig. 1. Incidental, asymptomatic solid nodule. Flowchart for evaluation of an incidentally detected solid pulmonary nodule. (1) The recommendations are offered as general guidance and do not apply to all patients. (2) Limited life expectancy and comorbidities that increase the risk of treatment or are more likely to cause morbidity and mortality than the suspected lung cancer, given the nodule size. (3) Risk based on relevant patient risk factors as per Fleischner criteria. (4) Size in millimeters is defined as the average of long- and short-axis diameters, both of which should be obtained in the same transverse, coronal, or sagittal reconstructed images. (5) Chest CT should be noncontrast and use low-dose technique.

Multiple Solid Pulmonary Nodules

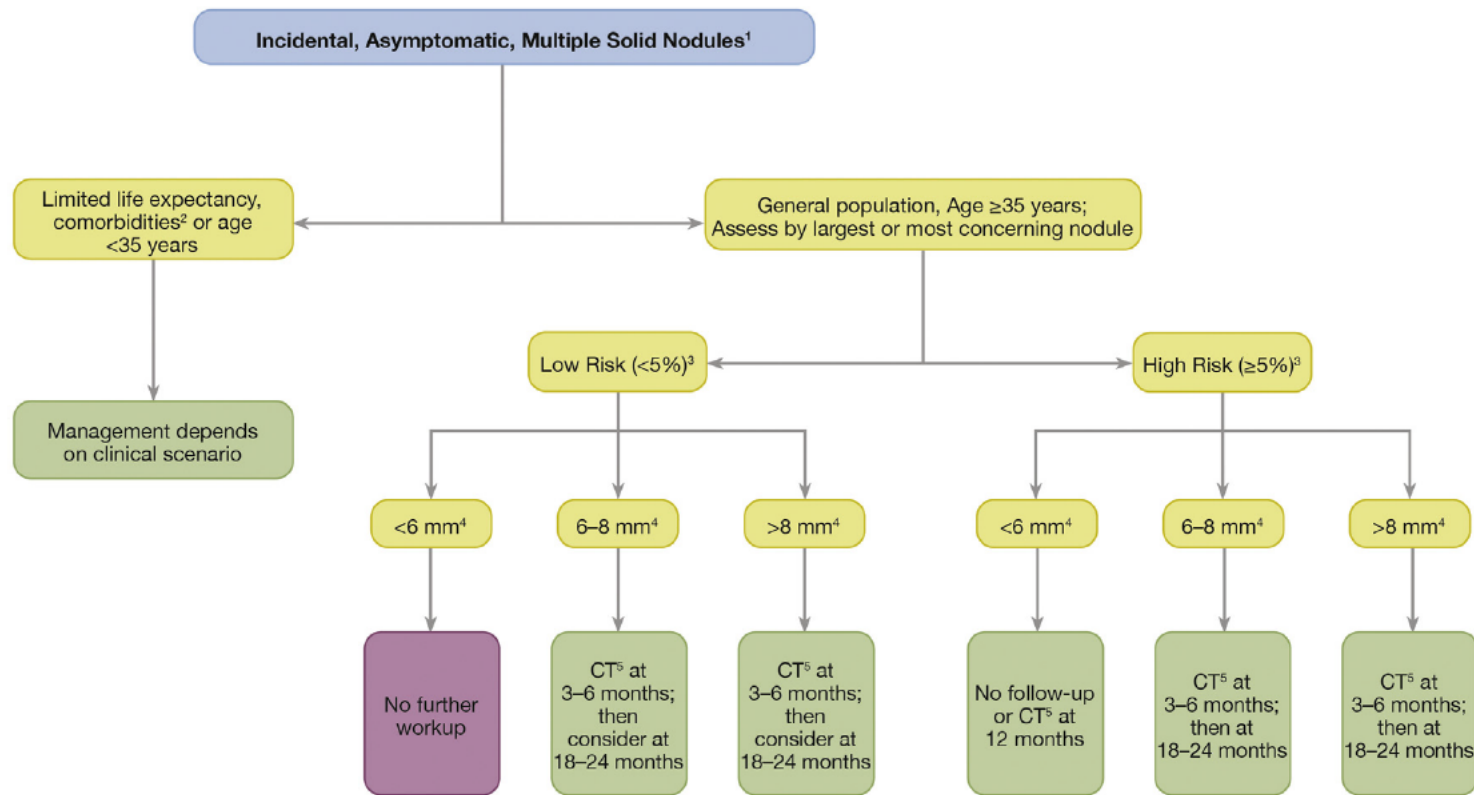


Fig. 2. Incidental, asymptomatic multiple solid nodules. Flowchart for incidentally detected multiple solid pulmonary nodules. (1) The recommendations are offered as general guidance and do not apply to all patients. (2) Limited life expectancy and comorbidities that increase the risk of treatment or are more likely to cause morbidity and mortality than the suspected lung cancer, given the nodule size. (3) Risk based on relevant patient risk factors as per Fleischner criteria. (4) Size in millimeters is defined as the average of long- and short-axis diameters, both of which should be obtained in the same transverse, coronal, or sagittal reconstructed images. (5) Chest CT should be noncontrast and use low-dose technique. Note: For multiple nodules, management is based on the largest or most concerning nodule.

Mixed Solid-Ground Glass Pulmonary Nodules

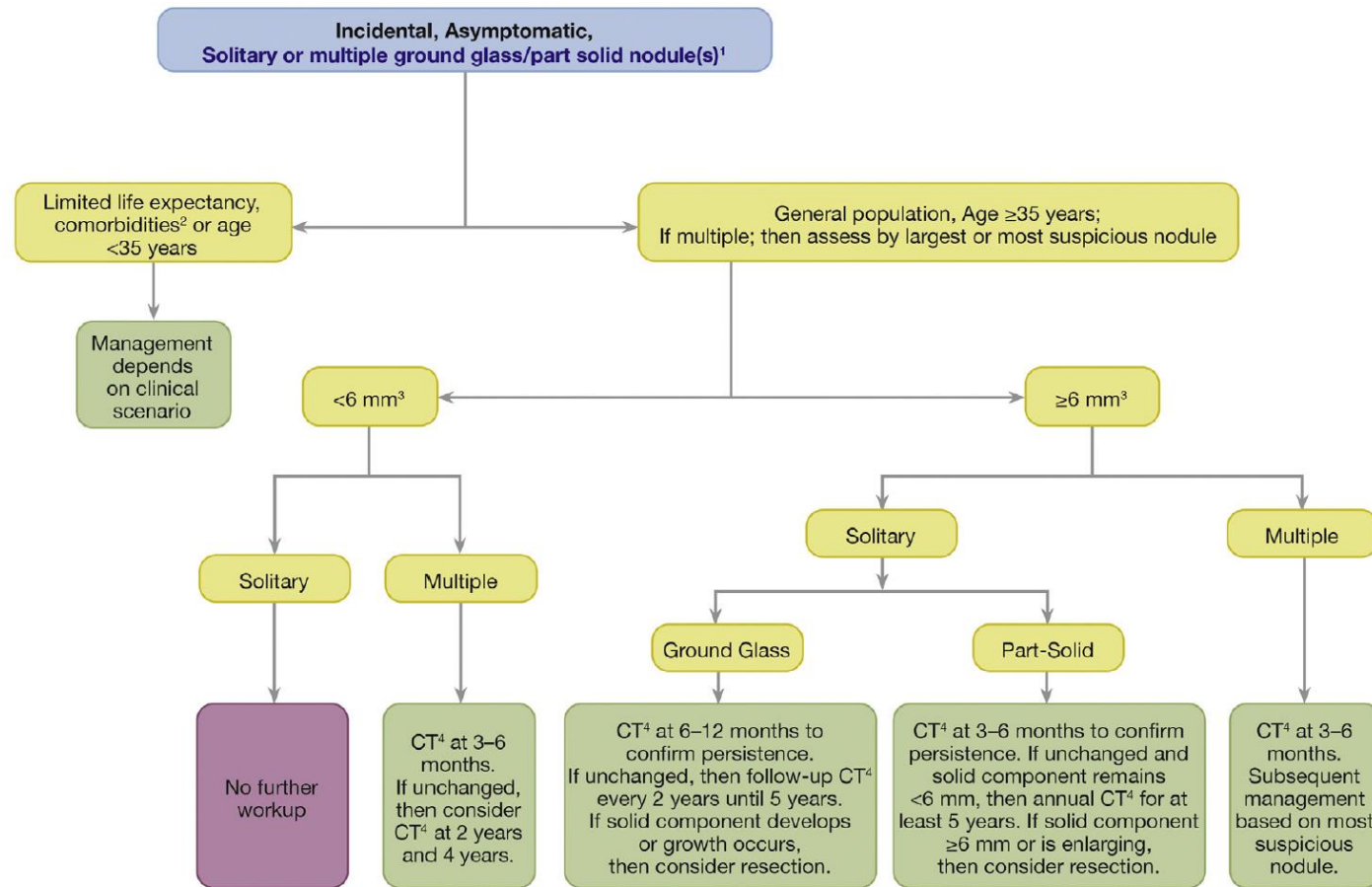


Fig. 3. Incidental, asymptomatic solitary or multiple ground glass or part-solid nodule(s). Flowchart for incidentally detected solitary or multiple ground glass or part-solid pulmonary nodule(s). (1) The recommendations are offered as general guidance and do not apply to all patients. (2) Limited life expectancy and comorbidities that increase the risk of treatment or are more likely to cause morbidity and mortality than the suspected lung cancer, given the nodule size. (3) Size in millimeters is defined as the average of long- and short-axis diameters, both of which should be obtained in the same transverse, coronal, or sagittal reconstructed images. (4) Chest CT should be noncontrast and use low-dose technique. Note: For multiple nodules, management is based on the largest or most concerning nodule.

Ground Glass Pulmonary Opacity

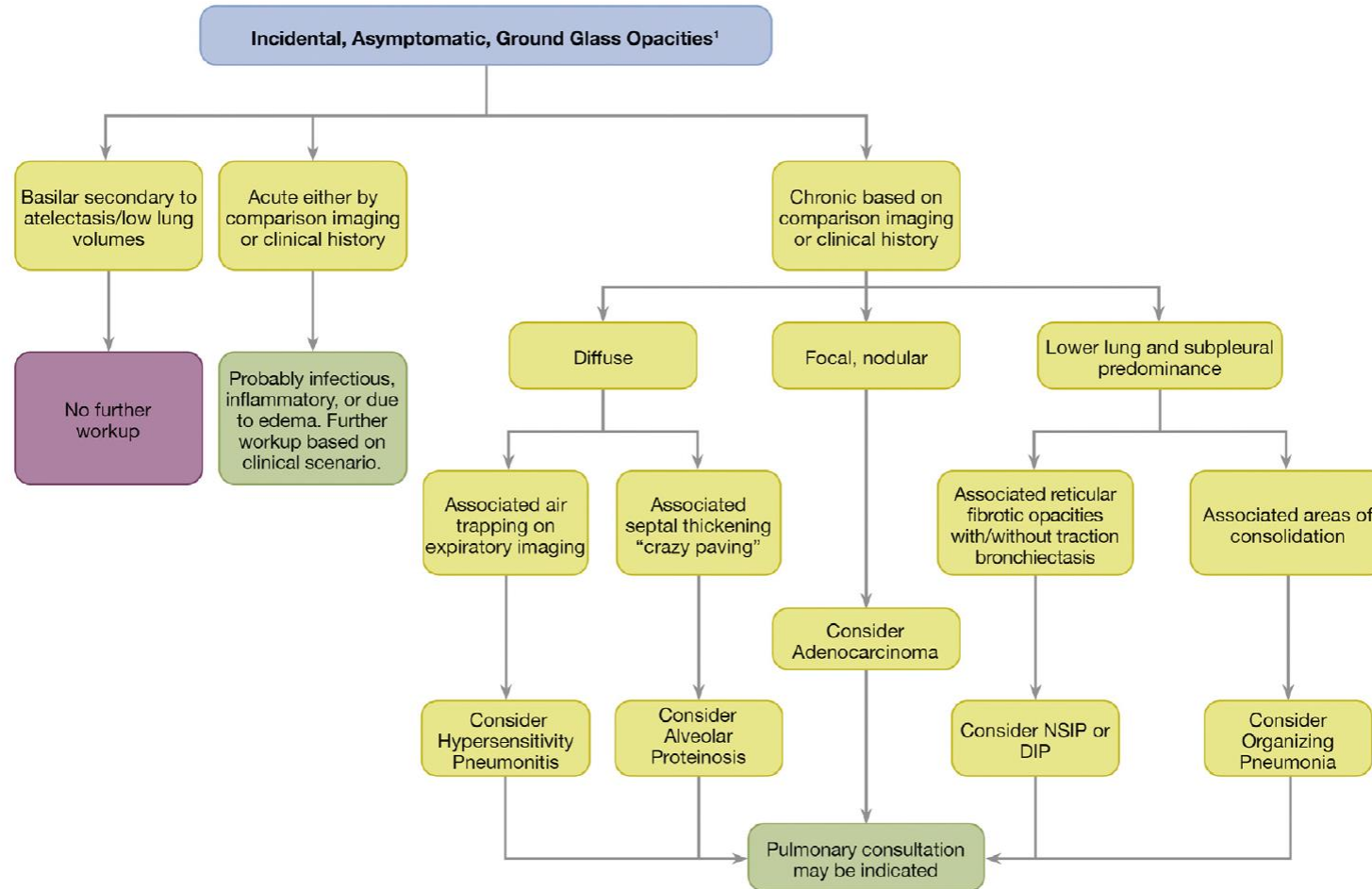


Fig. 5. Incidental, asymptomatic ground glass opacities. Flowchart for evaluation of incidentally detected ground glass opacities. (1) The recommendations are offered as general guidance and do not apply to all patients. DIP = desquamative interstitial pneumonia; NSIP = nonspecific interstitial pneumonia.

Thyroid Nodules

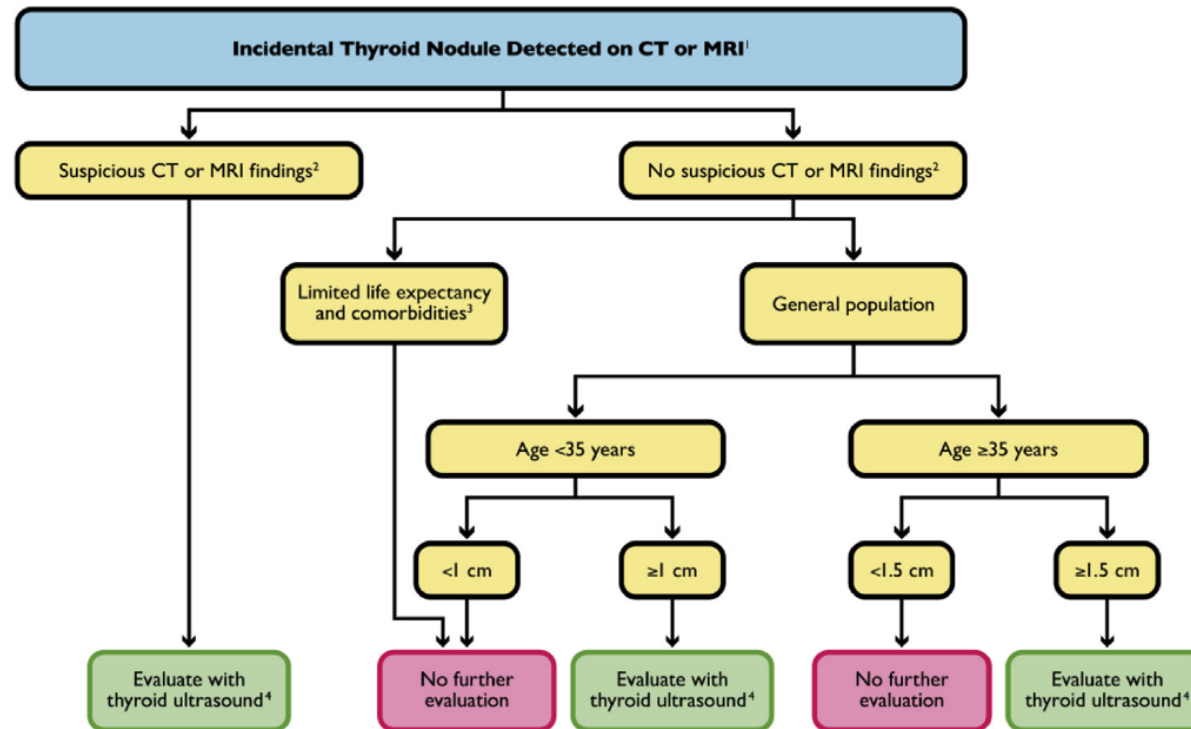


Fig 1. Flowchart for incidental thyroid nodules (ITNs) detected on CT or MRI. ¹The recommendations are offered as general guidance and do not apply to all patients, such as those with clinical risk factors for thyroid cancer. ²Suspicious CT/MRI features include: abnormal lymph nodes and/or invasion of local tissues by the thyroid nodule. Abnormal lymph node features include: calcifications, cystic components, and/or increased enhancement. Nodal enlargement is less specific for thyroid cancer metastases, but further evaluation could be considered if an ITN has ipsilateral nodes >1.5 cm in short axis for jugulodigastric lymph nodes, and >1 cm for other lymph nodes. ³Limited life expectancy and comorbidities that increase the risk of treatment or are more likely to cause morbidity and mortality than the thyroid cancer itself, given the nodule size; see text for details. Patients with comorbidities or limited life expectancy should not have further evaluation of the ITN, unless it is warranted clinically, or specifically requested by the patient or referring physician. ⁴Further management of the ITN after thyroid ultrasound, including fine-needle aspiration, should be based on ultrasound findings.

Adrenal Masses

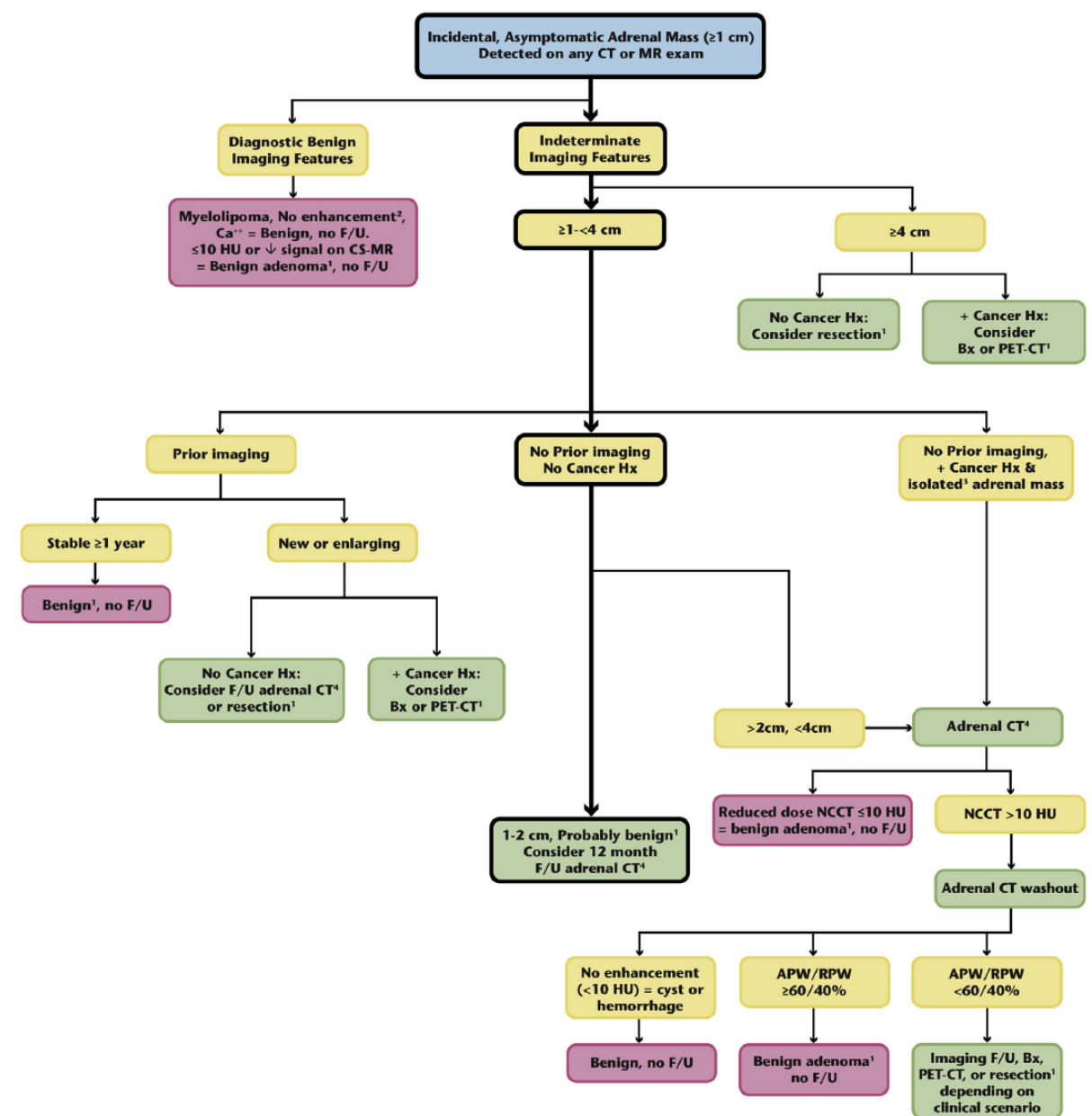


Fig 1. Algorithm for evaluation of an incidentally detected adrenal mass. (1) Consider biochemical assays to determine functional status and exclude pheochromocytoma before biopsy/resection. (2) "No enhancement" applies if an examination without and with intravenous contrast is available. (3) "Isolated" defined as no other metastatic disease identified. (4) May consider chemical-shift MRI (CS-MR). APW = absolute percentage washout; Ca⁺⁺ = calcification; F/U = follow-up; HU = Hounsfield units; Hx = history; NCCT = CT without intravenous contrast; RPW = relative percentage washout; + = positive.